Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Renaissance Hospital-Dallas
2929 S. Hampton Rd.
Dallas, TX 75224

Sent
JAN 04 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

MFDR Tracking #: M4-07-4498-01

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier:

Respondent Name and Box #:

American Interstate Insurance
Box # 01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)."

Principle Documentation:

1. DWC 60 package
2. UB-92(s)
3. EOB(s)
4. Invoices
5. Amount Sought $31,885.16
6. Attachments

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: None submitted.

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service	Part V Reference	Amount in Dispute	Amount Due
3-24-06 thru 3-30-06	Inpatient Hospitalization	1-12	$31,885.16	$29,120.72
Total Due:				$29,120.72

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code "42-Charges exceed our fee schedule or maximum allowable amount; 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider; 855-024-Service is denied for lack of proof of pre-authorization $0.00; W1-Workers compensation State Fee Schedule Adjustment; 855-002- Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines; 97-Payment is included in the allowance for another service/procedure; 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate; and W4-No additional reimbursement allowed after review of appeal/reconsideration."

2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6)(A)(i) states "To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold."

3. Based upon the operative report, the claimant underwent laminectomy at L4 and L5, posterior interbody fusion and posterolateral fusion at L4-5 with instrumentation.

4. On March 28, 2006, the claimant was taken back to the operating room to remove a retained lumbar drain. This procedure was done under general anesthesia and there were no complications.

5. The Respondent denied reimbursement for services rendered on 3/30/06 based upon lack of preauthorization. The Requestor did not submit documentation to support that preauthorization was obtained prior to rendering the services, or that these services were rendered based upon a medical emergency; therefore, per Rule 134.600, date of service 3/30/06 required preauthorization. Since written documentation was not submitted to the Division to support that preauthorization was obtained, no reimbursement is recommended for this date.

6. Based upon the itemized statement, the Requestor billed $3,685.92 for date of service 3/30/06.

7. Based upon the UB-92 the total charges were $147,710.80 for the inpatient hospitalization. This amount minus charges for date of service 3/30/06 = $144,024.88.

8. Because the total audited charges exceed $40,000, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

9. Rule 134.401(c)(6)(A)(iii), states "If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%."

10. Rule 134.401(c)(6)(A)(v), states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." The insurance carrier audited the bill and submitted EOBs to support their reduction of billed charges. The insurance carrier audited the bill and paid for services based upon the per diem methodology. No other audit reductions of charges were presented by Respondent.

11. Rule 134.401(c)(6)(B), indicates "Formula. Audited Charges X SLRF = WCRA." Therefore, the amount billed $144,024.88 X 75% = $108,018.66.

12. The insurance carrier audited the bill and paid $78,897.94 for the inpatient hospitalization. The difference between amount due and paid = $29,120.72.

Considering the reimbursement amount calculated in accordance with the provisions of Rule 134.401(c) compared with the amount previously paid by the insurance carrier, the Division finds that additional reimbursement of $29,120.72 is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.401
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $29,120.72 plus accrued interest per Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

[redacted] | [redacted] | 1-3-08

Authorized Signature | Director of Medical Fee Dispute Resolution | Date

DECISION:

[redacted] | [redacted] | 1-3-08

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.